PRINTED: 07/14/2011 FORM APPROVED

ENTERS FOR MEDICARE & MEDICAID SERVICES					OW	IB NO. 0938-0391	
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BIII	LDING	00	COMPI	LETED
		155714	B. WIN			06/20/2	2011
			B. WII		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIE	R		1			
0.414.1/11	LACEINO		200 W FOURTH ST OAKTOWN, IN47561				
OAK VIL	LAGE INC			OAKIC	DVVN, IN47561		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0000							
	This visit was fo	or a Recertification and	F(0000	By submitting the enclosed		1
	State Licensure		'`	,,,,,	material we are not admitting	g the	
	State Licensure	Survey.			truth or accuracy of any spe	cific	
					findings or allegations. We		
	Survey dates: Ju	ine 15, 16,17, 20, 2011			reserve the right to contest t		
					findings or allegations as pa		
	Facility number:	: 000517			any proceedings and submit		
	Provider number				these responses pursuant to		
	AIM number: 1				regulatory obligations. The	•	
	Anvi number. 1	00200770			requests the plan of correction	on be	
					considered our allegatin of	2011	
	Survey team:				compliance effective July 9, to the annual survey conduction		
	Liz Harper, RN-	· TC			on July 15th, 16th, 17th, and		
	Carole McDanie	el. RN			2011	1 2011,	
	Terri Walters, R				2011		
	· ·						
	Martna Sauli, Ki	N, June 15, 16, 17, 2011					
	Census bed type	:					
	SNF/NF: 31						
	Total: 31						
	10141. 31						
	C						
	Census payor ty	pe:					
	Medicare: 4						
	Medicaid: 21						
	Other: 6						
	Total: 31						
	10.001.						
	Sample: 10						
	Supplemental sample: 6						
	These deficiencies also reflect state						
	findings cited in accordance with 410 IAC						
	16.2.	accordance with 410 mic					
	10.4.						
	I		1		I		1

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 000517

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155714			(X2) MULTIPLE CO A. BUILDING B. WING	00		TE SURVEY IPLETED 1/2011		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 200 W FOURTH ST OAKTOWN, IN47561					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
	Quality review of 2011, by Bev Fa	ompleted on June 23, ulkner, RN						

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED
AND PLAN	OF CORRECTION	155714	A. BUILDING	00	06/20/2011
		1007 14	B. WING	DDDEGG CITY CTATE ZID CODE	00/20/2011
NAME OF F	PROVIDER OR SUPPLIER		l	DDRESS, CITY, STATE, ZIP CODE	
	LAGE INC		I	WN, IN47561	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)	TAG	DLI ICILICI I	DATE
F0225 SS=D	have been found gor mistreating resident have had a finding nurse aide registry mistreatment of resident of their property; a has of actions by a employee, which we service as a nurse the State nurse aid authorities. The facility must eviolations involving abuse, including in and misappropriating reported immediate the facility and to with State law through (including to the Stagency). The facility must halleged violations are	ot employ individuals who pullty of abusing, neglecting, dents by a court of law; or entered into the State concerning abuse, neglect, sidents or misappropriation and report any knowledge it a court of law against an would indicate unfitness for aide or other facility staff to de registry or licensing ansure that all alleged a mistreatment, neglect, or nijuries of unknown source ion of resident property are ely to the administrator of other officials in accordance augh established procedures tate survey and certification ave evidence that all are thoroughly investigated, further potential abuse while in progress.			
	reported to the addrepresentative and accordance with S State survey and c working days of the violation is verified action must be take Based on interview facility failed to compare the state of the	ew and record review, the ensure staff reported nessed verbal abuse and 1 of 1 resident	F0225	F225 F – 225 The correct action taken for those reside found to have been affected the deficient practice is the smember who was found to h been neglectful and verbally	nts by taff ave

CENTERS FOR MEDICARE & MEDICAID SERVICES						OM	B NO. 0938-0391
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	LTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	ETED
		155714	B. WING			06/20/2	011
			F		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIE	R			FOURTH ST		
OAK VIL	LAGE INC				DWN, IN47561		
(VA) ID	CUMMARY	CTATEMENT OF DEFICIENCIES	!		, T		(V5)
(X4) ID		STATEMENT OF DEFICIENCIES	l,	ID	PROVIDER'S PLAN OF CORRECTION		(X5) COMPLETION
PREFIX TAG		NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	'	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΓE	DATE
IAU	+	<u> </u>	+	IAG			DATE
	CNA#1, CNA#	#2, Resident #16			abusive following a thorough investigation was terminated		
					The staff member who failed		
					report the incident concerning		
	Findings include: On 6/16/11 at 1:45 P.M., the DON was				resident # 16 and CNA # 2 w	-	
					inserviced on policy and		
					procedure for reporting abuse	se	
		e indicated when staff			and/or neglect and received		
					day suspension at the discre	tion	
		im of an actual or alleged			of the DON. The corrective		
	1	he would have them			action taken to identify other residents having the potential		
	_	ten deposition to use as a			be affected is that all resider		
	follow up tool.	He indicated he would			have the potential to be affect		
	also interview th	ne resident and start an			The corrective action taken f		
	investigation. T	The DON indicated if the			those residents having the		
	_	ot significant" and			potential to be affected by th		
		middle of the night, he			same deficient practice is the		
					Policy & Procedure for repor	ting	
		I the morning to notify the			abuse has been revised to	h a	
		The DON gave an			include all suspected abuse reported immediately to the	be	
	_	ncident he would wait			charge nurse who will then	report	
		orning to notify the			to the DON and Administrate		
	Administrator of	f as having been a resident			immediately. The revision		
	to resident physi	ical altercation with no			contains disciplinary action f		
	injury and had n	not required the resident to			failure to report an incidence		
		al for evaluation. The			abuse immediately to Charg	e	
		if there was an incident of			Nurse. The measures or systemic changes that will be	_	
		verbal abuse during night			made to ensure that the defi		
		9 9			practice does not recur is that		
	hours, he would send the involved staff member home and would call the				all staff inservice was condu		
					to address what constitutes		
	Administrator th	ne next morning.			abuse and that there are no		
					insignificant incidents of		
	On 6/17/11 at 11 A.M., the Administrator				abuse/neglect Also specifica	-	
	provided a copy of an abuse investigation. This investigation was dated as the				the reporting of suspected al	ouse.	
					Further includes disciplinary action of a mandatory two (2)) day	
	1	ng 3/4/11 between 2 A.M.			suspension for failure to repo		
		planation of the incident			incident and can include		
	unu > 11.1VI. L'A	manation of the includin	1		1		I

PRINTED: 07/14/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	ILTIPLE CON	NSTRUCTION	(X3) DATE			
AND PLAN	OF CORRECTION	IDENTIFICATION NUM	BER:	A. BUILI	DING	00	COMPL	
		155714		B. WING			06/20/2	U11
NAME OF I	PROVIDER OR SUPPLIER	<u> </u>			STREET A	DDRESS, CITY, STATE, ZIP CODE	-	
						OURTH ST		
OAK VIL	LAGE INC				OAKTO\ 	WN, IN47561		
(X4) ID		STATEMENT OF DEFICIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDEL		l I	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ГЕ	COMPLETION
TAG	•	LSC IDENTIFYING INFO		+	TAG	termination. The corrective		DATE
	1	s not limited to, th				termination. The corrective actions taken to monitor and		
	following: "From conversation with					ensure performance is that a	l	
	1 ' '	ident) c/o (compla	ined			Quality Improvement Tool ha	S	
	1 '	(certified nursing				been implemented to monito		
	1	e was cold and we				reporting of suspected abuse This tool will be completed b		
		ed her arms in disg	_			Charge Nurse daily on each	-	
	1 ' '	out of the res roor				for three weeks and then wit	h	
		Another CNA did c	come to			each incidence of suspected		
	give res care"					abuse. Tools will be reviewe DON.daily Monday through F		
	1	so provided a copy	•			for three weeks and then wit		
	1 -	the above incident.				each incident. This informat		
	"	luded, but was not	t			will Also bereviewed each month		
	limited to, the fo	•				in QA meeting to see if further		
	1	0 A.M., on 3/4/11,				action is warranted. Complia Date 7-9-11	nce	
	1 -	ervice that (Reside				Date 1-0-11		
		she had been left v						
	1	night" At this tin						
	1 **	l's written statemen						
		undated and timed						
	statement include	ed, but was not lin	nited to,					
	1	I (CNA #1 name)						
	witness on 3/4/11	1 in Res (#16) room	m to					
	the aide (CNA #2	2) responding to						
	(Resident #16) cr	rying about wettin	g bed					
	and not able to g	et herself up to tra	nsfer to					
	the commode. C	CNA #2 stated 'Eve	eryone					
		s why your (sic) lil	-					
	1	, cause I'm not goi						
	CNA #1 documented "In the matter of							
	(Resident #16) (CNA #2 name) and I were							
	doing bed check up the long hall							
	(Resident #16) light went on and (CNA #2) said, "she'll have to wait." CNA #2							
documented "When we approached								
FORM CMS-2	2567(02-99) Previous Versio			1 21Z11	Facility II	D: 000517 If continuation s	heet Pa	ge 5 of 30

Event ID: 1Q1Z11

Page 5 of 30

DENTIFICATION NUMBER 155714 DO	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SU	JRVEY
NAME OF PROVIDER OR SUPPLIER OAK VILLAGE INC OX91D SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICENCY MUST BE PERCEDED BY FULL. TAG (RESIDENT H 16 room) I went to (Resident #17, Resident #16; soommate) to bed check while CNA #2 turned off light. Turned and started to answer (Resident #16) and raised her palm of her hand. I answered (Resident #16) when (Resident #16) was asking (CNA #2) for care during which time I was giving (resident #17) care." On 6/17/11 at 11 A.M., the Administrator was interviewed. She indicated that CNA #1 did not report the allegation of verbal abuse to anyone until she was notified to return to the facility for an interview. The Administrator indicated CNA #1 did witness the verbal abuse of CNA #2 to Resident #16. On 6/17/11 at 12:15 P.M., the DON was interviewed. He indicated CNA #1 had no action taken in response to her failure to report the verbal abuses be witnessed	AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIIII	DING	00	COMPLE	TED
NAME OF PROVIDER OR SUPPLIER OAK VILLAGE INC (X4) ID SUMMARY STATEMENT OF DEPICIENCIES (EACH DEPICENCY MUST BE PERCEDED BY PULL TAG (PACH CORBUST TO A STORE AND A STATE OF CORBECTION PACH CORBUST TO A STORE AND A STATE OF CORBECT TO A STATE OF CORBECT TO A STORE AND A STATE OF CORBECT TO A STATE OF CORBECT TO A STORE AND A STATE OF CORBECT TO A STATE OF CORBECT			155714	1			06/20/20	11
OAK VILLAGE INC (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG (Resident #16 room) I went to (Resident #17, Resident #16's roommate) to bed check while CNA #2 turned off light. Turned and started to answer (Resident #16) and raised her palm of her hand. I answered (Resident #16) light next time and changed her. Some of the small details may be a little different but (CNA #2) ignored (Resident #16) when (Resident #16) was asking (CNA #2) for care during which time I was giving (resident #17) care." On 6/17/11 at 11 A.M., the Administrator was interviewed. She indicated Resident #16 informed the Social Service Director of the incident (which occurred between 2 A.M 3 A.M.) the morning of 3/4/11. The Administrator also indicated that CNA #1 did not report the allegation of verbal abuse to anyone until she was notified to return to the facility for an interview. The Administrator indicated CNA #1 did witness the verbal abuse of CNA #2 to Resident #16. On 6/17/11 at 12:15 P.M., the DON was interviewed. He indicated CNA #1 had no action taken in response to her failure to report the verbal abuse she witnessed						ADDRESS, CITY, STATE, ZIP CODE		
SUMMARY SEATEMENT OF DEFICIENCIES ID PROUPERS PLANGE CONFICTION (CXS)	NAME OF F	PROVIDER OR SUPPLIER			200 W I	FOURTH ST		
REGULATORY OR LSC IDENTIFYING INFORMATION) (Resident #16's roommate) to bed check while CNA #2 turned off light. Turned and started to answer (Resident #16) and raised her palm of her hand. I answered (Resident #16) when (Resident #16) when (Resident #16) was asking (CNA #2) for care during which time I was giving (resident #17) care." On 6/17/11 at 11 A.M., the Administrator was interviewed. She indicated Resident #16 informed the Social Service Director of the incident (which occurred between 2 A.M 3 A.M.) the morning of 3/4/11. The Administrator also indicated that CNA #1 did not report the allegation of verbal abuse to anyone until she was notified to return to the facility for an interview. The Administrator indicated CNA #1 did witness the verbal abuse of CNA #2 to Resident #16. On 6/17/11 at 12:15 P.M., the DON was interviewed. He indicated CNA #1 had no action taken in response to her failure to report the verbal abuse she witnessed				_		0WN, IN47561		
(Resident #16 room) I went to (Resident #17, Resident #16 room) I went to (Resident #16) roommate) to bed check while CNA #2 turned off light. Turned and started to answer (Resident #16) and raised her palm of her hand. I answered (Resident #16) light next time and changed her. Some of the small details may be a little different but (CNA #2) ignored (Resident #16) was asking (CNA #2) for care during which time I was giving (resident #17) care." On 6/17/11 at 11 A.M., the Administrator was interviewed. She indicated Resident #16 informed the Social Service Director of the incident (which occurred between 2 A.M 3 A.M.) the morning of 3/4/11. The Administrator also indicated that CNA #1 did not report the allegation of verbal abuse to anyone until she was notified to return to the facility for an interview. The Administrator indicated CNA #1 did witness the verbal abuse of CNA #2 to Resident #16. On 6/17/11 at 12:15 P.M., the DON was interviewed. He indicated CNA #1 had no action taken in response to her failure to report the verbal abuse she witnessed								
(Resident #16 room) I went to (Resident #17, Resident #16's roommate) to bed check while CNA #2 turned off light. Turned and started to answer (Resident #16) and raised her palm of her hand. I answered (Resident #16) light next time and changed her. Some of the small details may be a little different but (CNA #2) ignored (Resident #16) when (Resident #16) was asking (CNA #2) for care during which time I was giving (resident #17) care." On 6/17/11 at 11 A.M., the Administrator was interviewed. She indicated Resident #16 informed the Social Service Director of the incident (which occurred between 2 A.M 3 A.M.) the morning of 3/4/11. The Administrator also indicated that CNA #1 did not report the allegation of verbal abuse to anyone until she was notified to return to the facility for an interview. The Administrator indicated CNA #1 did witness the verbal abuse of CNA #2 to Resident #16. On 6/17/11 at 12:15 P.M., the DON was interviewed. He indicated CNA #1 had no action taken in response to her failure to report the verbal abuse she witnessed		`				CROSS-REFERENCED TO THE APPROPRIAT	TE	
#17, Resident #16's roommate) to bed check while CNA #2 turned off light. Turned and started to answer (Resident #16) and raised her palm of her hand. I answered (Resident #16) light next time and changed her. Some of the small details may be a little different but (CNA #2) ignored (Resident #16) when (Resident #16) was asking (CNA #2) for care during which time I was giving (resident #17) care." On 6/17/11 at 11 A.M., the Administrator was interviewed. She indicated Resident #16 informed the Social Service Director of the incident (which occurred between 2 A.M 3 A.M.) the morning of 3/4/11. The Administrator also indicated that CNA #1 did not report the allegation of verbal abuse to anyone until she was notified to return to the facility for an interview. The Administrator indicated CNA #1 did witness the verbal abuse of CNA #2 to Resident #16. On 6/17/11 at 12:15 P.M., the DON was interviewed. He indicated CNA #1 had no action taken in response to her failure to report the verbal abuse she witnessed	IAG		·	-	IAG	BELIEFE.Y	+	DATE
check while CNA #2 turned off light. Turned and started to answer (Resident #16) and raised her palm of her hand. I answered (Resident #16) light next time and changed her. Some of the small details may be a little different but (CNA #2) ignored (Resident #16) when (Resident #16) was asking (CNA #2) for care during which time I was giving (resident #17) care." On 6/17/11 at 11 A.M., the Administrator was interviewed. She indicated Resident #16 informed the Social Service Director of the incident (which occurred between 2 A.M 3 A.M.) the morning of 3/4/11. The Administrator also indicated that CNA #1 did not report the allegation of verbal abuse to anyone until she was notified to return to the facility for an interview. The Administrator indicated CNA #1 did witness the verbal abuse of CNA #2 to Resident #16. On 6/17/11 at 12:15 P.M., the DON was interviewed. He indicated CNA #1 had no action taken in response to her failure to report the verbal abuse she witnessed		`						
Turned and started to answer (Resident #16) and raised her palm of her hand. I answered (Resident #16) light next time and changed her. Some of the small details may be a little different but (CNA #2) ignored (Resident #16) when (Resident #16) was asking (CNA #2) for care during which time I was giving (resident #17) care." On 6/17/11 at 11 A.M., the Administrator was interviewed. She indicated Resident #16 informed the Social Service Director of the incident (which occurred between 2 A.M 3 A.M.) the morning of 3/4/11. The Administrator also indicated that CNA #1 did not report the allegation of verbal abuse to anyone until she was notified to return to the facility for an interview. The Administrator indicated CNA #1 did witness the verbal abuse of CNA #2 to Resident #16. On 6/17/11 at 12:15 P.M., the DON was interviewed. He indicated CNA #1 had no action taken in response to her failure to report the verbal abuse she witnessed		· ·	,					
#16) and raised her palm of her hand. I answered (Resident #16) light next time and changed her. Some of the small details may be a little different but (CNA #2) ignored (Resident #16) when (Resident #16) when (Resident #16) was asking (CNA #2) for care during which time I was giving (resident #17) care." On 6/17/11 at 11 A.M., the Administrator was interviewed. She indicated Resident #16 informed the Social Service Director of the incident (which occurred between 2 A.M 3 A.M.) the morning of 3/4/11. The Administrator also indicated that CNA #1 did not report the allegation of verbal abuse to anyone until she was notified to return to the facility for an interview. The Administrator indicated CNA #1 did witness the verbal abuse of CNA #2 to Resident #16. On 6/17/11 at 12:15 P.M., the DON was interviewed. He indicated CNA #1 had no action taken in response to her failure to report the verbal abuse she witnessed		1						
answered (Resident #16) light next time and changed her. Some of the small details may be a little different but (CNA #2) ignored (Resident #16) when (Resident #16) was asking (CNA #2) for care during which time I was giving (resident #17) care." On 6/17/11 at 11 A.M., the Administrator was interviewed. She indicated Resident #16 informed the Social Service Director of the incident (which occurred between 2 A.M 3 A.M.) the morning of 3/4/11. The Administrator also indicated that CNA #1 did not report the allegation of verbal abuse to anyone until she was notified to return to the facility for an interview. The Administrator indicated CNA #1 did witness the verbal abuse of CNA #2 to Resident #16. On 6/17/11 at 12:15 P.M., the DON was interviewed. He indicated CNA #1 had no action taken in response to her failure to report the verbal abuse she witnessed		`						
and changed her. Some of the small details may be a little different but (CNA #2) ignored (Resident #16) when (Resident #16) was asking (CNA #2) for care during which time I was giving (resident #17) care." On 6/17/11 at 11 A.M., the Administrator was interviewed. She indicated Resident #16 informed the Social Service Director of the incident (which occurred between 2 A.M 3 A.M.) the morning of 3/4/11. The Administrator also indicated that CNA #1 did not report the allegation of verbal abuse to anyone until she was notified to return to the facility for an interview. The Administrator indicated CNA #1 did witness the verbal abuse of CNA #2 to Resident #16. On 6/17/11 at 12:15 P.M., the DON was interviewed. He indicated CNA #1 had no action taken in response to her failure to report the verbal abuse she witnessed		*						
details may be a little different but (CNA #2) ignored (Resident #16) when (Resident #16) was asking (CNA #2) for care during which time I was giving (resident #17) care." On 6/17/11 at 11 A.M., the Administrator was interviewed. She indicated Resident #16 informed the Social Service Director of the incident (which occurred between 2 A.M 3 A.M.) the morning of 3/4/11. The Administrator also indicated that CNA #1 did not report the allegation of verbal abuse to anyone until she was notified to return to the facility for an interview. The Administrator indicated CNA #1 did witness the verbal abuse of CNA #2 to Resident #16. On 6/17/11 at 12:15 P.M., the DON was interviewed. He indicated CNA #1 had no action taken in response to her failure to report the verbal abuse she witnessed		`	, 0					
#2) ignored (Resident #16) when (Resident #16) was asking (CNA #2) for care during which time I was giving (resident #17) care." On 6/17/11 at 11 A.M., the Administrator was interviewed. She indicated Resident #16 informed the Social Service Director of the incident (which occurred between 2 A.M 3 A.M.) the morning of 3/4/11. The Administrator also indicated that CNA #1 did not report the allegation of verbal abuse to anyone until she was notified to return to the facility for an interview. The Administrator indicated CNA #1 did witness the verbal abuse of CNA #2 to Resident #16. On 6/17/11 at 12:15 P.M., the DON was interviewed. He indicated CNA #1 had no action taken in response to her failure to report the verbal abuse she witnessed		_						
(Resident #16) was asking (CNA #2) for care during which time I was giving (resident #17) care." On 6/17/11 at 11 A.M., the Administrator was interviewed. She indicated Resident #16 informed the Social Service Director of the incident (which occurred between 2 A.M 3 A.M.) the morning of 3/4/11. The Administrator also indicated that CNA #1 did not report the allegation of verbal abuse to anyone until she was notified to return to the facility for an interview. The Administrator indicated CNA #1 did witness the verbal abuse of CNA #2 to Resident #16. On 6/17/11 at 12:15 P.M., the DON was interviewed. He indicated CNA #1 had no action taken in response to her failure to report the verbal abuse she witnessed			· ·					
care during which time I was giving (resident #17) care." On 6/17/11 at 11 A.M., the Administrator was interviewed. She indicated Resident #16 informed the Social Service Director of the incident (which occurred between 2 A.M 3 A.M.) the morning of 3/4/11. The Administrator also indicated that CNA #1 did not report the allegation of verbal abuse to anyone until she was notified to return to the facility for an interview. The Administrator indicated CNA #1 did witness the verbal abuse of CNA #2 to Resident #16. On 6/17/11 at 12:15 P.M., the DON was interviewed. He indicated CNA #1 had no action taken in response to her failure to report the verbal abuse she witnessed		, •	, , , , , , , , , , , , , , , , , , ,					
(resident #17) care." On 6/17/11 at 11 A.M., the Administrator was interviewed. She indicated Resident #16 informed the Social Service Director of the incident (which occurred between 2 A.M 3 A.M.) the morning of 3/4/11. The Administrator also indicated that CNA #1 did not report the allegation of verbal abuse to anyone until she was notified to return to the facility for an interview. The Administrator indicated CNA #1 did witness the verbal abuse of CNA #2 to Resident #16. On 6/17/11 at 12:15 P.M., the DON was interviewed. He indicated CNA #1 had no action taken in response to her failure to report the verbal abuse she witnessed		(Resident #16) w	vas asking (CNA #2) for					
On 6/17/11 at 11 A.M., the Administrator was interviewed. She indicated Resident #16 informed the Social Service Director of the incident (which occurred between 2 A.M 3 A.M.) the morning of 3/4/11. The Administrator also indicated that CNA #1 did not report the allegation of verbal abuse to anyone until she was notified to return to the facility for an interview. The Administrator indicated CNA #1 did witness the verbal abuse of CNA #2 to Resident #16. On 6/17/11 at 12:15 P.M., the DON was interviewed. He indicated CNA #1 had no action taken in response to her failure to report the verbal abuse she witnessed		care during which time I was giving						
was interviewed. She indicated Resident #16 informed the Social Service Director of the incident (which occurred between 2 A.M 3 A.M.) the morning of 3/4/11. The Administrator also indicated that CNA #1 did not report the allegation of verbal abuse to anyone until she was notified to return to the facility for an interview. The Administrator indicated CNA #1 did witness the verbal abuse of CNA #2 to Resident #16. On 6/17/11 at 12:15 P.M., the DON was interviewed. He indicated CNA #1 had no action taken in response to her failure to report the verbal abuse she witnessed		(resident #17) ca	re."					
3.1-28(c)		On 6/17/11 at 11 was interviewed. #16 informed the of the incident (v A.M 3 A.M.) the Administrate CNA #1 did not a verbal abuse to a notified to return interview. The ACNA #1 did with CNA #2 to Reside On 6/17/11 at 12 interviewed. He no action taken in to report the verb from CNA #2 to	A.M., the Administrator She indicated Resident e Social Service Director which occurred between 2 the morning of 3/4/11. For also indicated that report the allegation of myone until she was to the facility for an administrator indicated the test the verbal abuse of lent #16. 15 P.M., the DON was indicated CNA #1 had m response to her failure total abuse she witnessed					

PRINTED: 07/14/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLI AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155714			A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/20/2011		
	ROVIDER OR SUPPLIER LAGE INC		STREET ADDRESS, CITY, STATE, ZIP CODE 200 W FOURTH ST OAKTOWN, IN47561				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	CROSS-REFERENCED TO THE APPROPRI	(X5) COMPLETION DATE		
F0226 SS=D	written policies and mistreatment, neg and misappropriat Based on intervie facility failed to opolicy and procedobserved abuse to ultimately to the resident allegation Resident #16, CN Findings include On 6/16/11 at 1:4 interviewed. He would inform him abuse incident, h		F0226	F226 It is and shall continue be the facilities practice that incidents of abuse, neglect, mistreatment of residents of misappropriation of their properted immediately to the and the Administrator. The corrective action taken for the residents found to have been affected by the deficient practice is that the facility Policy and Procedure on prohibition of mistreatment, neglect and a form of residents and misapproperty was restered to include specific reporting abuse immediately to charge nurse who will immediately the incident to the DON and	t all r operty DON e hose en actice d abuse riation vised of ge report		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

1Q1Z11 Facility ID:

000517

If continuation sheet

Page 7 of 30

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155714 06/20/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 200 W FOURTH ST OAK VILLAGE INC OAKTOWN, IN47561 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE Administrator. The resident follow up tool. He indicated he would identified as resident #16 has also interview the resident and start an suffered no negative investigation. The DON indicated if the psychological outcome from this "incident was not significant" and event. The corrective action taken to identify residents having occurred in the middle of the night, he the potential to be affected by the would wait until the morning to notify the same deficient practice is that all administrator. The DON gave an example residents have the potential to be of an incident he would wait until the next affected by the deficient practice. morning to notify the Administrator of as The corrective action taken for those residents having the having been a resident to resident physical potential to be affected by the altercation with no injury and had not same deficient practice is that the required the resident to go to the hospital Policy and Procedure for for evaluation. The DON indicated if reporting abuse has been revised to include all suspected abuse be there was an incident of staff to resident reported immediately to the verbal abuse during night hours, he would charge nurse who will then report send the involved staff member home and to the Don and Administrator immediately. The revision would call the Administrator the next contains disciplinary action for morning. failure to report an incidence of abuse immediately to the charge On 6/17/11 at 11 A.M., the Administrator The measures or nurse. provided a copy of an abuse investigation. systemic changes that will be made to ensure that the deficient This investigation was dated as the practice does not recur is that an incident occurring 3/4/11 between 2 A.M. all staff in-service was conducted and 3 A.M. Explanation of incident with the revised Policy and included, but was not limited to, the Procedure on prohibition of mistreatment neglect and abuse following: "From conversation with of residents and misappropriation resident, res (resident) c/o (complained of resident property. In-service of) telling CNA (certified nursing addressed what constitutes assistant) that she was cold and wet. CNA abuse and specifically the reporting of suspected abuse. raised and lowered her arms in disgust The in-service also stressed that (sic) and walked out of the res room and there is no such thing that is did not return. Another CNA did come to considered an insignificant give res care..." At this time, the incidents of abuse/neglect. The in-service also emphasized that Administrator also provided a copy of her

1Q1Z11

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155714 06/20/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 200 W FOURTH ST OAK VILLAGE INC OAKTOWN, IN47561 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE investigation of the above incident. This the revised policy includes disciplinary action for confirmed investigation included, but was not abuse by an employee and for limited to, the following: "At failure to report an incident of approximately 10 A.M., on 3/4/11, I was abuse/neglect. The staff was also advised that a mandatory told by Social Service that (Resident #16) two (2) day suspension will be had told her that she had been left wet and enforced for failure to report cold during the night..." incident immediately and can result in termination. Residents On 6/17/11 at 11 A.M., the Administrator will also be protected from the potential threat of abuse by was interviewed. She indicated Resident relieving suspected staff member #16 informed the Social Service Director of their duties for not less than a of the incident (which occurred between 2 period of three days while a A.M. - 3 A.M.) the morning of 3/4/11. thorough investigation is conducted. All confirmed The Administrator also indicated that incidents of neglect/abuse CNA #1 did not report the allegation of involving a staff member will verbal abuse to anyone until she was result in termination. The notified to return to the facility for an corrective actions will be monitored to ensure the deficient interview. practice will not recur is that a Quality Improvement Tool has On 6/17/11 at 12:45 P.M., the DON was been implemented to ensure interviewed. He indicated the facility revised Policy and Procedure is available to all staff. All Policy currently did not have a policy and and procedures will be dated to procedure to address staff being ensure the most current one is disciplined in response to an abuse being used. Improvement allegation and/or actual abuse but Performance Tool will be completed daily by DON for three indicated the facility will develop one and weeks, monthly for three months implement it. and quarterly times3. This tool will be reviewed in monthly QA On 6/15/11 at 2 P.M., a current copy of meeting to see if further action is warranted. Compliance Date the facility policy and procedure was 7-9-11 received from the Administrator. The policy was undated. The procedure included, but was not limited to, the following: "1. Resident,

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

1Q1Z11

Facility ID:

000517

If continuation sheet

Page 9 of 30

PRINTED: 07/14/2011 FORM APPROVED OMB NO. 0938-0391

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155714		(X2) MULTIPLE CC A. BUILDING B. WING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED 06/20/2011
	PROVIDER OR SUPPLIER		200 W I	ADDRESS, CITY, STATE, ZIP CODE FOURTH ST DWN, IN47561	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
F0282 SS=D	familyconcerns neglectare to be form and forward Nursing (DON) a AdministratorT notify the Direct Services and/or t alleged concern in the allegation wire reported to the D and/or the Admin 3.1-28(a) The services prove facility must be pro in accordance with plan of care. Based on observe interview, the fact 1 Qualified Mediadministering pa professional nurs residents from a who were observe from a QMA dur	s regarding abuse, e recorded on a complaint ded to the Director of and/or the The charge nurse will also or of Nursing, Social he AdministratorIf the involves the charge nurse, Il be immediately ON, Social Services	F0282	F282 It is and shall continue be the facility's practice that services are performed by qualified persons/per their pl care. The corrective actic taken for the resident affected this deficient practice is that # 1 was given a verbal warniand was counseled on the regulation that a QMA consulicensed nurse before passir	an of on od by QMA ing
					ng a nent

000517

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155714 06/20/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 200 W FOURTH ST OAK VILLAGE INC OAKTOWN, IN47561 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE Findings include: indicating the need for medication and time the symptoms occurred. document in the record that the On 6/15/11 at 11:10 A.M., Resident #32 facility's licensed nurse was approached the medication cart from contacted, symptoms were which QMA#1 was passing medication. described, and permission was granted to administer the Resident #32 stated "I need some medication including the time of Tylenol." QMA#1 responded by saying contact, obtain permission to "OK, I'll bring some to your room." The administer the medication each QMA failed to consult a licensed nurse time the symptoms occur in the resident and ensure that the and prepared 2 tablets of Acetaminophen resident's record is cosigned by (generic Tylenol) 325 mg., which she gave the licensed nurse who gave to the resident. Before administering the permission by the end of the medication to the resident, she asked the nurse's shift, or if the nurse is on call by the end of the nurse's next resident where her pain was located. tour of duty. It should also be Resident #32 indicated she had a noted that the resident identified headache. The OMA administered the as resident #32 had no negative outcome from receiving the prn drug and instructed the resident to "Let dose of Tylenol. The measures me know if that doesn't help." The QMA or systemic changes that have returned to her cart, directly outside the been put into place to ensure the room of Resident # 32. At that point LPN deficient practice does not recur #1 came to the cart and asked the QMA is that a mandatory in-service was conducted for nursing staff for keys to open the other medication cart. and the QMA. Specifically The QMA provided keys but did not addressed was the regulation that inform the nurse of Resident #32's pain a QMA consult a licensed nurse or the administration of the and complete necessary documentation before passing a Acetaminophen. The OMA then PRN medication and that the documented the drug, date, time, and nurse authorizing the reason she had given the medication to administration of the prn Resident #32. medication co-signs the drug administration record. The corrective action taken to monitor The clinical record of Resident #32 was to ensure the deficient practice reviewed on 6/15/11 at 11:50 A.M. The does not recur is the that a resident had been admitted 5/13/11 and Quality Improvement tool was developed and implemented to had a physician order for 2

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

1Q1Z11

Facility ID: 000517

If continuation sheet

Page 11 of 30

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		00			(3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	155714	A. BUI	LDING	00	06/20/2011
		1557 14	B. WIN			00/20/2011
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE	
OVK VIII	LAGE INC			1	FOURTH ST WN, IN47561	
	_				7VVIN, 11N47 30 1	
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	DATE
1710		· · · · · · · · · · · · · · · · · · ·	-	ing	monitor the passing of PRN	DATE
	Acetaminophen 325 mg tablets by mouth every 4 hours prn (as needed) for pain or elevated temperature.				medications by a QMA. The	tool
					includes a review of all requi	
	eievated tempera	iture.			documentation components	
	A + 6/15/11 of 12:	50 P.M., LPN #1 was			the QMA and nurse are requesto complete upon the	irea
	interviewed regar				administration of a prn	
		n medication. She			medication. This tool will be	
	• • •	ieved it was fine for			completed by the Charge Nu	
		rn medications without			each day a QMA is utilized ir facility. This tool will be	ı uie
					monitored by the DON week	ly
	consulting the nurse unless the prn's were narcotics and Acetaminophen was not a				times 3 weeks, monthly time	s 3
					months and quarterly times	
	narcotic.				The outcome will be reviewe Monthly Quality Assurance	d in
	The Director of N	Jurging provided the			meeting to see if further action	on is
		Nursing provided the			warranted. Completion Date	
		cription "MED PASS			7-9-11	
		OR LPN" on 6/17/11 at				
		rected "QMA to report to				
		PRN medications				
	given."					
	The C4040 male 41	21462105				
		2 IAC 2-1-9 Scope of				
		ence to QMAs was 7/11 at 1:00 P.M. It				
	`	ied Medication Aide Rule				
		on page 5 which read as				
	follows:					
	"Administar mass	riought ordered mas as				
	1	viously ordered pro re				
		ation only if authorization				
		the facility nurse on duty				
		horization is obtained,				
	the QMA must d					
	` '	n the resident record				
	symptoms indica	ting the need for				

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT	(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR 00 COMPLETE				
AND PLAN	OF CORRECTION		A. BUILDII	NG	00		
		155714	B. WING			06/20/2	UII
NAME OF P	ROVIDER OR SUPPLIER		I .		DDRESS, CITY, STATE, ZIP CODE		
OAK VII I	_AGE INC				OURTH ST WN, IN47561		
		DATE OF DEPLOYED AND			,		(1/5)
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL	1	D EFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		AG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	DATE
		me the symptoms					
	occurred.	ine the symptoms					
		the resident record that					
	the facility's Lice						
		oms were described, and					
		granted to administer the					
		ding the time of contact.					
		ission to administer the					
		time the symptoms occur					
	in the resident.						
	` ′	the resident's record is					
		icensed nurse who gave					
		e end of the nurse's shift					
	or, if the nurse is	on call, by the end of the					
	nurse's next tour	of duty."					
	3.1-35(g)(2)						
F0222	The facility must o	nours that the resident					
F0323 SS=G	_	nsure that the resident ins as free of accident					
33-G		sible; and each resident					
		supervision and assistance					
	Based on observa	ntion, interview and	F032	3	F323 F323 It is and shall		07/09/2011
	record review, th	e facility failed to ensure			continue to be the facility's		
	interventions wer	re formulated, revised or			practice that the facility ensure that the resident environment		
	implemented to a	ddress multiple falls for			remain as free of accident	-	
		eviewed for falls in the			hazards as is possible; and e	ach	
	sample of 10. Th	nis practice resulted in			resident receives adequate		
	_	ng and sustaining a hip			supervision and assistance		
		tion, the facility failed to			devices to prevent accidents. 1. The corrective action taken		
		were in place to prevent		-	the resident found to have be		
		zards posed by the			affected by the deficient prac	tice	
	Cir i i cimi cittat ilt	zaras posea o y me			is that resident #1 careplan I	nas	
FORM CMS-2	567(02-99) Previous Version	ns Obsolete Event ID:	 1Q1Z11	Facility II	D: 000517 If continuation sh	neet Pag	ge 13 of 30

l i ´					(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		155714	B. WIN	IG		06/20/2011
NAME OF F	PROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE	
TWINE OF I	NO VIDEN ON SOLVEIEN				FOURTH ST	
OAK VIL	LAGE INC			OAKTO	WN, IN47561	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
facility vacuuming system					been audited to ensure all	
Resident #1 and 18					interventions are dated. New	
					interventions have been implemented to help prevent	
	resident with the				further falls. All fall assessme	
	Findings include:				will be completed according	
	1 mamgs merade	•			Policy and Procedure. It sho	
	1 The eliminal re	ecord of Resident #1 was			also be noted that the reside	nt
					identified as resident #1 has	
		5/11 at 11:15 A.M.			had any falls since the surve	
	-	led but were not limited			The corrective action taken to identify other residents having	
	_	History of Right Hip			potential to be affected is that	·
	Fracture, Demen	tia, History of Stroke,			residents identified as being	
	Chronic anemia a	and dysarrhythmia. The			risk have the potential to be	- 13
	admission MDS	(Minimum Data Set			affected. The corrective acti	on
	assessment), date	ed 10/19/10, indicated the			taken for those residents hav	- 1
	following for the	·			the potential to be affected b	
	_	nent; transfers and			same deficient practice is the	
		red extensive assistance;			Falls Committee has been fo to review all residents who a	
	•				risk for falls. An audit was	le at
		e was required for			performed to ensure that all	
	_	sident was admitted to			residents with a risk for falls	has
	the facility on 10	/6/10.			the proper interventions	
					careplanned and the proper	.
	A care plan, date	d 10/7/10, identified the			documentation. The commit	
	following problem	m: "At risk for falls due			meets each day Monday thru Friday to review any new fall	
	to hx of falls et (a	and unsteady gait."			interventions, documentation	·
	,	luded, but were not			medications, diagnoses, and	
		llowing: "Transfer et			careplan, Fall Investigation	
		one assist; pull alarm at			Report and nurse's notes. I	
	` ′	ht within reach; up in wc			shuld also be noted that the	
	_	(as needed) when			investigation includes potent cause factors. This informat	
	` *	` '			then utilized to determine	01110
	unsteady on feet; pressure pad alarm at all times" Documentation was lacking as to the dates of implementation of the				appropriate interventions to t	pe
					utilized in an attempt to preven	
					future falls. The measures	or
	interventions.				systemic changes put into pl	ace
					to ensure that the deficient	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155714 06/20/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 200 W FOURTH ST OAK VILLAGE INC. OAKTOWN, IN47561 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE Nurses notes indicated the following for practice does not recur is that an all nursing staff inservice was the resident: conducted on the proper procedure for completing the fall 10/6/10 at 4:20 P.M.: "...Resident is alert risk assessment, nurse's notes and the plan of care. but confused, pressure pad alarm placed The corrective action taken to ensure on resident's bed at this time..." the deficient practice does not recur is the implementation of a 10/6/10 at 7 P.M.: "...Taking other Quality Performance Tool. This resident's alarm off had to sit her where tool is a follow up check list to be completed with each fall. This she can not reach other resident's tool will be monitored by the DON alarms..." as each fall occurs. This tool will be reviewed daily along with the 10/7/10 at 5:50 A.M.: "...This nurse has Fall Investigation Report and the nurse's notes, careplan and Fall answered her alarm 9 x in under 30 Risk Assessment during the Fall minutes. Will cont (continue) to monitor Committee meeting. 2. The et (and) provide interventions..." corrective action taken for the resident (#18) found to have been affected by the deficient practice 10/9/10 at 7 P.M.: "...very confused. is that the Safety Committee has Attempting to stand et walk 12 x's (times) completed a house wide in 30 minutes..." inspection of the facility to identify any safety hazards. Housekeeping has also implemented the 10/9/10 at 8:30 P.M.: "...yelling at staff et practice of wet to dry mopping of other res. Res cont (continue) to try to get the dining room floors. It should up out of chair. Staff having to provided also be noted that the resident 1:1 with res." identified as resident #18 has not had any falls since the survey. The corrective action taken to 10/10/10 at 1:30 A.M.: "...Res requires a identify other residents having the lot of one on ones d/t (due to) increased potential to be affected is that all confusion...Pressure pad in place et residents have to potential to be affected. The corrective action working properly but res still stands up taken is that a house wide per self et ambulates." inspection of the facility has been completed to identify any safety 10/10/10 at 10 A.M.: "...has been hazards. Any potential safety hazards that were identified have standing up several times this A.M..."

I '		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY						
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	ETED	
		155714	B. WIN			06/20/2	011	
		<u>I</u>			ADDRESS, CITY, STATE, ZIP CODE			
NAME OF	PROVIDER OR SUPPLIEF	₹		200 W FOURTH ST				
OAK VII	LAGE INC			OAKTOWN, IN47561				
				<u> </u>				
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	,	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE	
					been corrected. The measu			
	10/10/10 at 7:10 P.M.: "up in chair at				or systemic changes put into			
	nurses station, co	ont to try to get out of			place to ensure that the defic			
	chair, 1:1 attention				practice does not recur is an staff inservice has been	all		
	Chan, 1.1 attenti	on given			conducted specific to safety	and		
					identifying and reporting of s			
	1	A.M., (Fall #1):			hazards due to construction	-		
	"Resident was fo	ound on the floor at the			any other hazard. Maintena			
	north side of the	nurses station. The			has been inserviced on the F			
	alarm (pressure	pad) was sounding. The			and Procedure for identifying	•		
	1 .	less (sic)a pull alarm			removing safety hazards.			
	was added"	iess (sie)a puii aiaiiii			Housekeeping was inservice	ed on		
	was added				the practice of wet to dry mo	pping		
					of the dining room floors. T	he		
	11/3/10 at 9:10 F	P.M., (Fall #2): "Res got			corrective action taken to en			
	up et as CNAs (0	Certified Nursing			the deficient practice does no			
	1 -	going to assist res to			recur is the implementation			
	1	ore CNAs could reach res			Quality Performance Tool. T	his		
					tool will be completed by Maintenance daily times 3 w	ooko		
		ds et hit head on wall on			then monthly times 3 months			
	way to floor"				then quarterly for three quart			
					This tool will also be used da			
	11/4/10 at 1 A.M	I.: "Nurse of (hospital			any time there is construction			
	name) ER (emer	gency room) called (sic)			the facility. This tool will be			
		hematoma to back of			monitored by Administrator a	and		
	1 ^	outerized tomography)			reviewed in monthly QA mee	eting		
	· · ·	C 1 37			to see if further action is			
	scan neg (negati	ve)"			warranted. A Quality Perform			
					Tool has also been implemen			
	11/4/10 9 A.M.:	"cont with knott [sic]			for Housekeeping Superviso			
	et bruise on back	c of head"			This tool will be completed 1			
					daily for three weeks, weekly times four weeks and quarte			
	11/5/10 at 9:20 Z	A M (Fall #3): This			for three quarters. The outcome	-		
	11/5/10 at 9:20 A.M., (Fall #3): This nurse was alerted by res alarms sounding. Res was standing in west hall way. This nurse attempted to reach res. Unable to				of these tools will be reviewe			
					QA meeting to see if further			
					action is warranted. 3. Th	е		
					corrective action taken for th	ose		
	stop res from fal	ling on bottom. Fall			residents found to have beer	า		
	witnessed by this				affected by the deficient prac	ctice		

000517

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	00			(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	155714	A. BUII	LDING	00	06/20/2	
		1337 14	B. WIN			00/20/2	011
NAME OF	PROVIDER OR SUPPLIE	3		1	ADDRESS, CITY, STATE, ZIP CODE FOURTH ST		
OAK VIL	LAGE INC				-OURTH 51 WN, IN47561		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	,		(X5)
PREFIX		NCY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	· `	LISC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	DATE
IAG	alarm next to be movementPPA while up in w/c D/C (discontinuoremoves per self 11/5/10 at 6:30 I CNA was assisti wing bathroom a sounding. As I was lying in bed the hall with ancheard pressure pringing. Aide trabefore aide could backwards and hall in w/c, standalarm" 11/11/10 at 4 P.M. hall in w/c, standalarm"	I., "Pressure floor mat d to alert staff to (pressure pad alarm) (wheelchair) or chair. e) pull tab alarm d/t res.		IAG	identified as vacuuming of flis that no specific residents videntified. The corrective act taken for those residents have the potential to be affected by deficient practice is that all residents have the potential taffected. The corrective activates for those residents with potential to be affected is that Policy and Procedure for the vacuuming of floors has been developed and implemented. The measures or systemic changes put into place to ensure that the deficient practice do not recur is that all Housekes staff was inserviced on the pland procedure for vacuuming. The corrective action taken to ensure the deficient practice not recur is the implementational Quality Performance Tool. tool will be used by Houseke Supervisor 1x daily for three weeks, weekly for three weeks, weekly for three quarters. tool will be reviewed in the monthly Quality Assurance meeting to see if further actic warranted. Compliance date 7-9-11	vere etion ring y the ro be on the t a n sure es eping olicy o does on of This eping Ks, nd This	DATE

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) M A. BUII		INSTRUCTION 00	(X3) DATE S COMPL	
		155714	B. WIN			06/20/2	011
	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE FOURTH ST IWN, IN47561		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
	had been up and pad alarm ringing landed on bottom 11/14/10 at 5:20 nurse was approach haskg (housekeep res sitting on floor 11/14/10 at 6:50 nurse was on east personal alarm so nurse. Noted at 1 laying on floor of side of head on e (residents)slight R leg" 11/14/10 at 10:30 (hospital name). A policy and procurrence was read alarm so nurse. Noted at 1 laying on floor of side of head on e (residents)slight R leg" 11/14/10 at 10:30 (hospital name). A policy and procurrence was read alarm so nurse. Noted at 1 laying on floor of side of head on e (residents)slight R leg"	ting at nurses station, down all shift. Pressure g. Saw resident fall, h. Did not hit head" A.M., (Fall #8): "This teching nsg. station et ing) alerted this nurse to be with alarm sounding" A.M., (Fall #9): "This the wing hall when bounded, alerting this the wing hall when bounded, alerting this NS (nurses station) resent r (right) side with R dge of w/c next to res's to the inward rotation of the control of the control of the many control of the inward rotation of the control of the control of the purpose of this bout was not limited to,Document the events of centTo investigate and courrences with the intent					

000517

PRINTED: 07/14/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S COMPLI	
AND PLAN	OF CORRECTION	155714	A. BUI	LDING	00	06/20/20	
		1007 14	B. WIN			00/20/20	711
NAME OF I	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE		
OAK VIL	LAGE INC			1	FOURTH ST WN, IN47561		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	,		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	limited to the foll	lowing: "Complete all					
	information on th	ne Incident/Accident					
	report form. Do	not leave blanksFollow					
	up documentation	n is to be done by the					
	nurse on each shi	iftFill out post fall					
	assessment form	for 3 consecutive days					
	following the inc	ident/occurrence and					
	when form is cor	mpleted turn into DON."					
	On 6/16/11 at 1:2	20 P.M., the DON was					
	interviewed. He	indicated the resident					
	had a history of f	falls at home prior to her					
	admission to the	facility. He also					
	indicated the foll	owing information:					
	Regarding the 11	/3/10 fall (Fall #2), he					
	didn't know what	intervention was put					
	into place after th	nis fall as a preventative					
	measure. Also w	ith the 11/3/10 fall, the					
	DON indicated the	he resident was found in					
	the hall, but didn	't know which alarm was					
	sounding. Regar	ding the 11/5/10 fall (Fall					
	#3), the DON inc	licated he didn't know					
	what, if any, prev	ventative intervention					
	was put into plac	e and if one was put into					
	place, it wasn't de	ocumented. For the fall					
	on 11/5/10 (Fall a	#4) and 11/9/10 (Fall #5)					
	and 11/11/10 (Fa	ll #6) and 11/12/10 (Fall					
	#7) and 11/14/10	at 5:20 A.M. (Fall #8),					
		ed no new preventative					
	intervention was	documented. The DON					
	indicated that the	facility "tried to keep					
	her occupied." H	Ie indicated the fall on					
	11/14/10 at 6:50	A.M., resulted in a					
	fracture to the res	sident's right hip. The					

Facility ID:

PRINTED: 07/14/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		ì		INSTRUCTION 00	(X3) DATE S COMPL		
ANDILAN	OF CORRECTION	155714	- 1	LDING		06/20/2	
		1007 14	B. WIN		Paraga gray gray gray gar	00/20/2	511
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE FOURTH ST		
OAK VIL	LAGE INC			1	WN, IN47561		
(X4) ID	SUMMARYS	TATEMENT OF DEFICIENCIES		ID			(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΙΤΕ	DATE
	DON indicated a	t this time that the					
	resident's room v	vas on the West hall.					
	2. The clinical re	ecord of Resident # 18					
	was reviewed on	6/15/11 at 11:00 A.M.					
	Diagnosis includ	ed but were not limited					
	to Dementia and	History of falls. The					
		Set Assessment MDS) of					
		I the resident had fallen					
	since the last asso	essment. The nurses'					
	notes reflected a	fall since the 3/16/11					
	assessment.						
	Accounts of each	fall were provided by					
	the Director of N	fursing (DON) on 6/15/11					
	at 1:00 P.M. The	e accounts were Fall					
	Investigation Rep	ports. The Fall					
	Investigation Rep	ports indicated falls were					
		hazards. One on					
	1	.M., indicated the					
		en on a roll of carpet in					
	West hallway du	e to "new carpet being					
	· ·	g." The prevention					
	_	to prevent additional					
	1	carpet over to wall and					
		s closely in hallway with					
	rolls of carpet."						
	Another fall on 3	/21/11 at 11:00 A.M.,					
	occurred when a	ccording to the report, the					
		on the dining room floor,					
	1 ^^	om mopping. The					
	planned interven						
	_	dry mop flooring in the					
		r wet mopping it. During					

Facility ID:

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155714		(X2) MULTIPLE C A. BUILDING	ONSTRUCTION 00	li i	E SURVEY PLETED //2011	
	PROVIDER OR SUPPLIEF		200 W	ADDRESS, CITY, STATE, ZIP FOURTH ST DWN, IN47561	_	
(X4) ID PREFIX	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE HE APPROPRIATE	(X5) COMPLETION
TAG	interview with the 1:45 P.M., he income and the wet floor	te DON on 6/15/11 at dicated the carpet obstacle were not recognized in revention until after the ed.	TAG	Date (Clare)		DATE
	floors was obser 6/17/11 between A.M., when Hou the internal wall two halls with a the vacuum head. Throughout the part the carpet with the expanse the leng doorways, crossis was unable to victraffic in the area. In interview, dur. Housekeeper #1	system of vacuuming yed on 6/16/11 and 7:55 A.M. and 8:20 sekeeper #1 was utilizing suction ports in one of 50 foot hose attached to to sweep hall carpeting. Process, she vacuumed he hose trailing behind an th of 3-4 resident higher each threshold. She was potential resident he behind her. In the observation, indicated she was aware watched since it's a				
	vacuuming syste resident halls and keep good hose of vacuuming was to "when resident the halls but it do	2:10 P.M., the approvisor indicated the m was installed in both d staff were instructed to control. She indicated the to be done primarily as are eating and out of pesn't always work that 's done anytime of day."				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MUL	TIPLE CON	NSTRUCTION	(X3) DATE S COMPL		
AND FLANC	or correction	155714	A. BUILDI B. WING	ING	00	06/20/2	
NAME OF PI	ROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
OAK VILL	AGE INC				OURTH ST VN, IN47561		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID PROVIDER'S PLAN OF CORRECTION			(X5)	
PREFIX	•	CY MUST BE PERCEDED BY FULL		REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	COMPLETION
F0371 SS=F	On 6/20/11 at 2:0 Housekeeping State facility did not had procedure for care 3.1-45(a)(1) 3.1-45(a)(2) The facility must - (1) Procure food from considered satisfal local authorities; a (2) Store, prepare, under sanitary con Based on of interview a review, the ensure staff sanitation	om sources approved or ctory by Federal, State or nd distribute and serve food ditions bservation, and record facility failed to f prepared solution per icy, failed to	F037	71	F371 F371 It is and shall continue to be the facility's pot to procure food from sources approved or considered satisfactory by Federal, State local authorities and to store, prepare, distribute and serve	food The e tice vere	07/09/2011

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPLETED	
		155714	B. WIN	G		06/20/2011	
	PROVIDER OR SUPPLIER LAGE INC	TATEMENT OF DEFICIENCIES	STREET ADDRESS, CITY, STATE, ZIP CODE 200 W FOURTH ST OAKTOWN, IN47561				
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION	
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	DATE	
	solution, fa	iled to ensure			potential to be affected by the same deficient practice. The	:	
	paper towe	ls were available			corrective action taken for the	ose	
		accessible for			residents is that a trash receptacle with a foot pedal f opening has been placed in t		
	drying of h	ands after			kitchen for disposal of paper		
	washing an				towels used to dry hands. The paper towel dispenser is che	cked	
	ensure the	trash receptacle			daily by housekeeping to ens dispenser is full The Proce	dure	
	had the app	propriate lid to			to setting up the sanitizer but has been posted in the kitche	en	
	prevent cor	ntamination of			and the correct testing strips been identified and placed in		
	hands when	n discarding			kitchen. The measures or systemic changes put into pla		
	paper towe	ls during 3 of 4			to ensure that the deficient practice does not recur is that		
	observation	n days with the			inservice has been conducte	d for	
	potential to	affect 31 of 31			kitchen and housekeeping st specific to the issues identifie	ed.	
	residents w	ho received			In addition all dietary staff ha successfully completed a reti	urn	
	meals from	the facility			demonstration on how to test sanitizing solution in accorda		
	kitchen.	J			with facility policy and proced	dure.	
	Findings include: On 6/15/11 at 10:00 A.M., an observation in the kitchen indicated the paper				The corrective action taken ensure the deficient practice not recur is the implementation a Quality Performance Tool. tool will be completed by Die and Housekeeping staff daily	does on of This tary	
					times three weeks, monthly t three months and quarterly ti	mes	
					three quarters. The results w reviewed in monthly QA to	vill be	
					determine is further action is		
	1				warranted. Completion Date 7-9-11		
	tower arspe	enser was empty			. •		

Facility ID:

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155714		ĺ	LDING	NSTRUCTION 00	(X3) DATE S COMPL 06/20/2	ETED	
	PROVIDER OR SUPPLIER	.		200 W F	ADDRESS, CITY, STATE, ZIP CODE FOURTH ST WN, IN47561		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
	at the hand	washing sink.					
	Towels we	re obtained out					
	of the cabin	net above the					
	sink after h	and washing					
	was comple	eted by Cook #					
	1. The lid	on the trash					
	container to	o discard the					
	paper towe	ls after use had					
	to be lifted	and replaced by					
	hand after	discarding the					
	paper towe	1.					
	On 6/20/11	at 10:00 A.M.,					
	the paper to	owel dispenser					
	above the h	nandwashing sink					
	was empty.	. Cook # 1					
	indicated th	nat housekeeping					
	would be b	ringing some in					
	if there we	re no towels in					
	the cabinet	above the sink.					
	There were	no towels in the					
	above cabi	net, only the					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155714		(X2) MUL A. BUILD B. WING		NSTRUCTION 00	(X3) DATE S COMPL 06/20/2	ETED	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 200 W FOURTH ST OAKTOWN, IN47561				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PF	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	(X5) COMPLETION DATE
	outer paper	wrapper that					
	contained t	them. The lid on					
	the trash ca	an had to be					
	handled by	hand to discard					
	the paper to	owel (or any					
	other item	being discarded).					
	On 6/15/11	at 10:05 A.M.,					
	Cook # 1 w	vas asked to test					
	the sanitati	on solution.					
	Cook # 1 ii	ndicated there					
	was not a s	olution bucket					
	prepared th	at morning and					
	proceeded	to set one up to					
	test using b	oleach and water.					
	The test wa	as completed					
	with Quate	rnary					
	Ammoniur	n Compound					
	(QAC) stri	ps whereas the					
	color indicate	ator did not					
	match the o	original					
	container.	The test strips					

PRINTED: 07/14/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155714		ĺ	LDING	NSTRUCTION 00	(X3) DATE S COMPL 06/20/2	ETED	
NAME OF I	PROVIDER OR SUPPLIER	<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
OAK VIL	LAGE INC			1	FOURTH ST WN, IN47561		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	original co	lor was yellow					
	and turned	white in color					
	after being	dipped. The					
	indicator li	ne on the					
	container v	vas in shades of					
	green. Coo	ok # 1 indicated,					
	"100 ppm"	while holding it					
	next to the	first green shade					
	on the resu	lts line of the					
	bottle and	nodding his head					
	as the strip	matched the					
	first block.						
	On 6/16/11	at 9:30 A.M.,					
	Dietary Ai	d#1 was asked					
	to test the	sanitation					
	solution. 7	The strip was					
	dipped into	the solution					
	water and 1	the strip turned a					
	purple color. Cook # 1						
	indicated the	he Dietary Aid#					
	1 used the wrong testing						

Facility ID:

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155714			LDING	NSTRUCTION 00	(X3) DATE COMPI 06/20/2	LETED	
	PROVIDER OR SUPPLIER		<u> </u>	200 W F	ADDRESS, CITY, STATE, ZIP CODE FOURTH ST WN, IN47561	-	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
	strip and re	emoved a					
	container of	of testing strips					
	(QAC) from	m his pocket and					
	gave to her	to use to test the					
	solution. A	Again the test					
	strip was w	hite in color and					
	did not ma	tch the shades of					
	green on th	e indicator line					
	of the origi	nal container to					
	show the a	mount of					
	sanitation s	solution present					
	in the wate	r.					
	On 6/17/11	at 9:00 A.M.,					
	Cook # 1 to	ested the					
	sanitation s	solution using the					
	(QAC) yell	low strips. He					
	dipped the	strip into the					
	solution an	d the strip turned					
	pale white	in color not					
	matching the	he indicator line					
	of greens.						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155714		(X2) MI A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE COMPI 06/20/2	LETED	
	PROVIDER OR SUPPLIER		<u> </u>	STREET A	DDRESS, CITY, STATE, ZIP CODE FOURTH ST WN, IN47561	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	an interviewindicated ustrips to test solution had was prepar for the staff. On 6/20/11 Cook # 1 procedures sanitizer but Procedures 1. Use onlibuckets with fill water list should be a degrees. 2. Place 1/bleach in expression of the staff.	at 10:15 A.M., rovided the to setting up the ackets. are as follows: y 2 buckets, fill th hot water to ne # 5 and water					

AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING		00	COMPLETED		
155714		B. WING			06/20/2011 			
NAME OF I	PROVIDER OR SUPPLIER	8		STREET ADDRESS, CITY, STATE, ZIP CODE 200 W FOURTH ST				
OAK VILLAGE INC				OAKTOWN, IN47561				
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL DEFINITION OF LIGHT STATEMENT ATTOMATION)			ID PREFIX	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF		(X5) COMPLETION	
TAG	PH strip and hold for 10			TAG	DEFICIENCE		DATE	
	seconds and check against							
	the scale. It should always							
	be at 50-100 ppm (parts per							
	million).							
	3. Sanitizing solution							
	buckets should be make at 6							
	A.M., after breakfast, lunch							
	and supper.							
	If at anytime buckets							
	become soiled, they are to							
	be changed, in addition to							
	the specific times.							
	Bucket on cart is for							
	non-food sanitizer. Bucket							
	on counter is for food							
	sanitizer.							
	0 (20/11 + 10.20 + 3.5							
	On 6/20/11 at 10:20 A.M.,							
	observation of the Precision							
		est Paper bottle						
	Instruction	s indicated: Use						

AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155714			A. BUILDING B. WING		COMPLETED 06/20/2011					
NAME OF PROVIDER OR SUPPLIER OAK VILLAGE INC				STREET ADDRESS, CITY, STATE, ZIP CODE 200 W FOURTH ST OAKTOWN, IN47561						
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			IID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFIDERICAL CROSS-REFERENCED TO THE APPROFIDERICAL CROSS-REFERENCED TO THE APPROFIDERICAL CROSS-REFERENCED TO THE APPROF			(X5) COMPLETION DATE			
	dry fingers to remove strip									
	of paper from vial, dip strip									
	into solution to be tested,									
	without agitation and									
	compare and compare									
	immediately with color									
	chart on label. This color									
	indicates approximate									
	strength of the solution in									
	parts per million (ppm)									
	available chlorine.									
	3.1-21(i)(2))								